Comments Received in Response to Draft Report

I don't see what the big deal is about Registered Counselors! There are LMHC and LCSW who are certified as professional counselors and the Registered Counselor license makes it possible for MHC and Social Workers to obtain the hours necessary to be licensed MHC and SW.

Having a 5-year deadline is very unfair. It may be that someone wants to take longer to obtain 3,000-4,000 hours of supervised counseling and with this deadline, a person could not take his/her time, work parttime and still eventually obtain his/her LMHC or LCSW certificate.

Registered Counselor does simply mean that someone is registered with the State. I am assuming that when I applied for my registered counselor that the State did a criminal check on me. Is this not true?

Just educate the public what a "Registered Counselor" means. I am using my registered counselor to work and obtain my hours necessary for my LCSW credential.

I read all the meeting minutes and having a Master's Degree in relation to obtaining a registered counselor license was not discussed. Only 20 continuing education hours that should be at the AA level and should have five years to complete.

I am a Barbara Brennan Healing Science practitioner, a type of holistic healthcare practitioner. My four year training is acknowledged and insured by the Associated Bodywork and Massage Professionals Association. In addition to my Barbara Brennan School of Healing diploma, I have a high school diploma and have completed three years of university study in psychology. The Brennan School of Healing is licensed by the Commission for Independent Education, Florida Department of Education to grant Professional Studies Diplomas in Brennan Healing Science®, the specialized form of holistic healthcare taught at BBSH. My training consists of 1,780 hours of in-person classroom time, including 80 hours of Anatomy and Physiology. I receive monthly supervision from a former teacher at the Brennan Healing School.

I help clients to connect with the mind-body-spirit connection and develop meditative skills. My clients include ministers, psychologists, western and holistic medical professionals, law enforcement officers, business professionals and homemakers. I do not diagnose or treat mental or physical illness. My education has fully trained me to discern and refer all of my clients with mental health and medical concerns to the appropriate licensed professionals.

I am working in three locations here in Bellingham. I work as an independent contractor at the Cancer Center of St. Joseph Hospital, my private practice, and at the Chrysalis Spa. I am unclear how my employment could be affected by the changes you are suggesting. My understanding is that I could no longer work in any of my three locations without being licensed in some way by the state. Please let me know if I eligible for an exemption, or another type of licensure.

As a mental health client and member of the public I am confused as to how these new requirements would serve to better protect me from an individual wishing to engage in unethical practices at my expense?

My counselor/therapist is required to provide me with a disclosure clearly stating that it is illegal to have sexual contact with me or to otherwise take advantage of me financially or emotionally. I do not see how requiring greater educational requirements would lessen this risk to myself or others in my position as a client. The ability to study well and pass exams does not make one ethical.

I am also deeply concerned by a lack of evidence showing that those with greater education are less likely to offend or make better counselors. As well as a lack of answers to the obvious situation which will likely develop, as those in the current program fail to meet the new requirements leaving thousands of clients without services and a lack of qualified professionals to pick up the slack.

The sad fact is that with these new requirements a number of highly successful counselors will be forced to abandon their clients causing great psychic harm simply due to finances or other factors limiting their

ability to gain the required education. While others will continue to do harm and take advantage of the vulnerable by virtue of education.

I have not seen any evidence presented as to the numbers of registered counselors with higher level eductions who abuse by comparison to those without college level credits. This would seem to be a basic piece of information necessary if one is to accurately evaluate the requirements and make an informed recommendation to the governor. The fact that such a basic comparison is missing deeply disturbs me as it should anyone affiliated with the decision making process.

I would encourage the task force to take a closer look at the facts relating to abuse before making any recommendation on a matter which so deeply affects the well being of those who are vulnerable to abuse.

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1) Allow the grandfathering...or you'll create another huge, unregulated population that you won't be able to track. Nevada has no "registered counselor' designation, and everyone just calls themselves a "coach", opens an office in their front room and goes for it. Don't think you want to go there.

2) Education: Please follow DOH's requirements for licensure...ie require 12 credits in "4 of the following areas". Some of use with older education has ethics built into every class, but my transcripts do not specifically list 'ethics' - even though I have a MEd.

Make this education available through the community college on-line system. A 6 week class for 1 or 2 credits is totally doable for just about everybody, and they'd be able to get their 12 credits within 3 years...and if you have the broader list of approved categories, you'll end up with a better trained group of providers.

See Community Colleges of Southern Nevada and their "Ed-To-Go" section - it's great!

Oh - even better - ...I've got my 'certificate of Gerontology"...perhaps we come up with a similar 'certificate' that meets about stated requirements..."Certificate of Counseling I and II and III" would be an easy way for the state to track this registered counseling process, people can clearly id the difference between I (basic level of ed), II - BA level of ed, and III - MA level of ed...etc. and DOH/DOL has a clearly defined process that will differentiate between the levels of education.

AND

You could add an 'endorsement' layer - like the education department - so people could identify the areas of expertise that they've gained additional training/practice in. For example, even though I'm just a registered counselor at the moment, I've got all my credentials and experience to be a DV treatment provider. This clearly separates me from someone who is a 'hynotherapist'.

By the way, you're definitions have left out the DV treatment providers - despite having taken 120 hours of specialized training as required by DSHS/WAC, most won't qualify under your definitions. Perhaps a 'caveat' that allows "or as authorized in other sections of the WAC"...

3) Written agreement with LMHP...I think a better approach would be to have us provide our 'chain of command' so to say. I can not refer all people to just one person. Their needs and my initial assessment determine where I would refer them - it could be CDp, it could be LMHP, it could be Family and Marriage, it could be a dietician or a hypnotherapist to stop smoking. If I had to provide a 'map' of my network, then the state would also have a better grasp of the impacts of a 'complaint', and know who is working in a vacuum.

also, make this a LMHP or equivalent...depending on the community it may be a LICSW, etc.

As to 'contact hours' requirement, this is a burden on those who only provide services a few hours a week or month. It's also a burden on the contracted provider. Another layer of micro-managing we don't need. I just think it's important to know that we have a network we work within that gives our clients access to anything they may need to be healthy.

4) Make the timeline for 'licensure' 8 years...those of us who are single parents, working full time somewhere else with great benefits and doing this on the side need that grace period - or our kids are going to need more than just 'counseling'...

5) I think the best way to ensure the public is educated is to add the categories to the disclosure statement, with a individual practitioners statement as to where they fall in those categories, and where/to whom they'd refer if the individuals needs fall outside their treatment parameters. (this is the 'map' in action) It automatically educates, increases awareness, and should something happen with provider A, the client has a list of all these other folks to move on to...

A client moving on to another provider for a consistently reported provider complaint would raise an internal flag, and hopefully a complaint to the state. Wouldn't it be nice if we set this network up so any client knew they could call anyone on the list if they questioned the ethics, practice or direction of their treatment? Wow - transparency in treatment. Could we so empower the public?

On that note, I'd like to say that the issue should not just be regulation of this class of service, it should be education and empowerment of our clients.

Wow, clearly a thoughtfully created document in such a short amount of time! Impressive. I only have one question. I am still unclear as to whether successful completion of national exam is required for Pre-Licensure of MFTA and MHCA category? This was the case for me in Arizona (I am in the process of licensure in WA and AZ). I think it is vital that individuals successfully pass the exam prior to pre-licensure, especially the ethics portion.

I have a question regarding registered counselors license (RCL). I applied for RCL when I was looking for jobs and I recognized maybe easier for me to find a job with this license. In fact, friend of mine had this license and recommended me to have one and I saw some job descripitons required this license at that time. However, I thought it will be useful for me, I was not required to have RCL for my past jobs. (I believe this license is required to have for mental health positions?)

Here is my question. Once I applied for this license, do I need to keep paying every year? Is there any way to freeze or giving up this license and re-apply when needed? I'm also registered as a nursing assistant and no longer needed to be registered unless I keep former job as on-call. Anoter situation I come up with is when I move to other states, there's no need to keep these licenses until I need them again, right? If you could direct me to the right person with this matter, I'm really appreciated.

I read the proposal. I have only one concern, and that was the naming. I am not sure the names intuitively reflect the hierarchy you are looking to set up.

Lay people think of therapists (such as psychotherapists) or mental health workers (e.g. mental health counselor) and counselors as doing the same work. However, counselors are more approachable (e.g. only mentally sick people go see people who have the name therapy/therapist or mental health in their titles). This can be seen by how many private practice psychotherapists advertise as counselors in the phone book and not as psychotherapists or mental health counselors (their consumers respond better to that term).

So, to a lay person, a counselor is a well trained person and they would not understand that a Mental Health Counselor Associate has a higher training requirement then an Unaffiliated Counselor.

I would expect many people to think an Unaffiliated Counselor is someone able to independently practice counseling whereas a Mental Health Counselor Associate would be a helper or in a related field (e.g. Associates in membership organizations typically mean someone interested in the area and maybe in a related field but not trained in that organizations area.) Associate is often used for a Jr. person and they would not intuitively understand that an Unaffiliated Counselor is private practice had a lower requirement for education and experience (e.g. no internship) then a Associate Mental Health Counselor.

I don't like the alternative choices of mental health technician, as the label technician implies the person only does limited technical work (e.g. x-ray technician), and does not accurately reflect what the people in this category that do private practice or group work.

Also Agency Affiliated Counselor only tells a lay person they work along with that Agency, and does not indicate training level minimums. While most people sign up for the Agency and not the particular counselor, knowing the min. requirement for training might help reduce the tendency to give the counselor a lot of power in the relationship and prevent abuse of power by the counselor.

I would propose using an intuitive hierarchy. Such as Licensed, Pre-licensed, and Unlicensed. Or Licensed, Unlicensed, and Lay.
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For example:
Licensed Mental Health Counselor (Licensed Marriage & Family Therapist, Licensed Social Worker))
Pre-Licensed Mental Health Counselor (Pre-Licensed Marriage & Family Therapist, Pre Licensed Social Worker)
Unlicensed Independent Counselor or Unlicensed Counselor or Unlicensed Lay Counselor.
Unlicensed Agency Affiliated Counselor
Note: I like using Unlicensed Independent Counselor as it clearly shows the two categories are similar in their requirements (e.g. no BA or MA needed), but tells that one works with an agency and the other works independently, which is what they do.

OR

Licensed Mental Health Counselor (Licensed Marriage & Family Therapist, Licensed Social Worker))
Unlicensed Mental Health Counselor (Unlicensed Marriage & Family Therapist, Unlicensed Social Worker)
Independent Lay Counselor
Agency Affiliated Lay Counselor or Agency Affiliated Counselor (without the hierarchy name it does not indicate min. training level though).
Note: I like using "Independent" along with Lay Counselor for the non-affiliated category as it clearly shows the two categories are similar in their requirements (e.g. no BA or MA needed), but tells that one works with an agency and the other works independently, which is what they do.

Thanks for the update. I am a hypnotherapist who felt that $140. (approximately), was too much to pay for what I do for free, so I let that registration go. CEU's are a necessary evil, so try to get that as law. A lot of people won't continure their educations, which might rid us of the bad counselors.

I have worked not only in the military as a counselor and in the civilian sector as well. I fell on there should be consideration for those counselors that have worked for years with no negative results and they should be grandfathered. I also feel those who worked as counselors in the military should be given special consideration. There are a lot of fabulos counselors out there that have helped many and ths should not be discredited through more goverment controls. There truly needs to be less government rules, regulations and controls, and the past record of individuals should be considered.

It is appearing to be one more thing that the government has found a way to bring in more revenue and controlling people. I feel it is less about the program and more about the control. The government has way too much control as it is and that in itself is the causation for more people needing to seek counselors.

Thank you for the draft report. In talking to Dianne Cox a member who attended all meetings, she stated that there was discussion about "Grandfather clause" for those people like me who has 25 years experience (17 years on inpatient psych unit, and 7 years on King county crisis team and 8 years in an outpatient clinic providing in home services). I have 10 years as a RC working part time in my private business while working full time at Children's Hospital. I have been in my own full time private practice for 5 years with no complaints. My focus is working with families who have autistic children. I travel from Bellingham, Oak Harbor, Mercer Island, I currently have contract with DSHS, DDD and a in home respite provider. I have worked for Family Law CASA of King County and Catholic Community Services. I have attended national conferences in Washington D.C and other local conference and worked at and sponsoring conference with Tony Atwood recently through and agency that I currently I contract with. Is there a clause that considers those in practice , in good standing, with a well known reputation and currently earning $70,000 year. WITH NO COMPLAINTS ON RECORD. I have many letters of recommendation from families, Psychologist and child Neurologist and Psychiatrist in my file to share . If you cannot answer this question who can I refer it too?

Fine as written. Thank you for your support.

Thank you for the information regarding the Registered Counselors (RC). I support the need for changes and to pull the RCs under a better defined as well as comprehensive state umbrella. This will improve services offered to clients as well as make each provider more responsible for their services and consistent. And hopefully expand the ability to increase referral sources for those who qualify.

As I was reading through the information I realized there is a related field not covered in this information. Psychometrists are excluded from this when I believe they too should meet similar standards for "associate" level licensed counselors. Psychometrists administer and score psychological and neuropsychological assessments but do not provide interpretation of the data results. However, currently there is NO regulation for their services when I believe there should be some. Each psychometrist does not currently work independently without a licensed PhD supervisor. However, since some are in private practice they do contract independently with private practice PhD practioners without state guidelines of their own. Requiring minimum educational, hours of practice (experience), supervision, and continuing education would be beneficial additions for performing this important occupation/service.

Psychometrists work with all age groups including children, adults and geriatrics. Populations include but are not limited to psychiatric, neurological (Parkinson's, epilepsy, multiple sclerosis, vascular, etc.), traumatic brain injuries, dementia, developmental, educational, learning disabilities/ADD/ADHD, vocational, forensics and others. Referral sources include state agencies such as the Department of Labor and Industries and federal agencies such as Immigration and Naturalization Services.

Currently, there are no states that I am aware of that require psychometrists meet any state mandated requirements. With the State of Washington activily pursuing changes to RCs this would be an opportune time to require Psychometrists to also be "certified" or a limited license.

The National Association of Psychometrists and the Board of Certified Psychometrists offer national certification based on educational, direct related experience and a rigorous national exam to become certified. I believe this method is applicable for psychometrists in the State of Washington.

Please review the information available on both websites: http://napnet.org and http://psychometristcertification.org/.

I'm ccing this to two executives on the Board of Certified Psychometrists should you have any questions you may want to inquire about. Please feel free to contact me directly if you have any questions.

I have reviewed the report and minutes and am still unclear about the possible issues related to experienced professionals already licensed in other states. I earned a M.A. in Counseling in 1975 at San Francisco State University and have held an active MFT license in California for the last 30 years, as well as a CEU provider license for the last 5 years, offering training and case supervision. Will this cluster of education, out-of-state license, experience, and expertise be recognized as sufficient for "grandfathering" either a Registered Counselor or Marriage and Family Therapist license? It would seem an unreasonable hardship to demand another examination or other requirements beyond existing, well-earned credentials. I am now 74, maintaining a modest part-time practice in Bellingham. My situation may not be common, but any new laws should recognize the value of other state's licensing and not unfairly burden older, experienced professionals.

Since your last presentation. I have spent a significant time researching the failure of the Hawaii program from both the Counselors , and doctors still practicing under the restrictions imposed under their system and will meet with a doctor working with the Veterans administration they I have known since I assisted him in getting into there field while I was at the University of Washington Comprehensive Needs Study! Since he has never been impressed with the restrictions imposed by this licensing programs restrictions and the problems created by its implementation , I will wait until I meet with him before making any further comments! The other two licensed Counselors that I have known are in the process of preparing their reports on the ineffectiveness of this program for me and should be delivered in the very near future!

I'm struggling to see the difference between the proposed registration level and the current licensure level. Also, for someone like me with training in the field of counseling (I had to do a lengthy internship, practicum, Masters level study) I am struggling to understand why I could not use my School Counselor credential to become a fully registered counselor. I use the skills every day and I don't think it is right to lump me in with the peer counselors. It is certainly not the same thing.

Thank you for keeping me on the email list regarding the registered counselor evaluation process. I appreciate the recommendation of an agency-affiliation designation and its recognition that our employers are ultimately responsible for our ethical practice. l believe this makes far more sense than the current practice of individually registering those of us in such positions and will be glad to see this new designation implemented, if the Governor's office approves it.

My follow-up questions concern the details of the current recommendations and registration; there is a section on pg 7 of the report that states that health care providers and those who do not charge a fee are exempt from the counseling registration (see below). Both of these qualifications apply to me, as I am employed by a hospice and as no fee is ever charged to clients for my service. Does this mean that although I've paid for the last 3 years to be covered as a registered counselor that, I've actually been exempt this entire time?? If so, I'd hope to have that money refunded to me. I just sent in my fee for the coming year this past week. I've copied the language of the report below for your consideration in this regard.

Thanks again for keeping me in the loop of this process. It looks like the task force did a thorough, thoughtful job.

Exemptions
The law regulating registered counselors exempts some professions from registering as counselors, see RCW 18.19.040. Attorneys, federal employees, college students, pastoral counselors, social science researchers, and other health care providers acting within their scopes of practice are exempt. People who counsel and do not charge a fee are also exempt.

Thanks for sending the info. My request is that some kind of grandfathering be instituted for Master's level counselors. I rec'd my M.A. in 1974 and have been practicing in both agency and private practice - with CPS, DV/SA, and Crime Victims. My level of experience is enormous.

I am 60 years old. I intend to keep practicing for many years to come at the same level. I missed the opportunity to be grandfathered into LMH, and now it is too many years past to get documentation of my supervised hours.

I do not consider myself to be among the people who are practicing counseling without education or experience.

How will DOH take into account my situation and others like me who started working in the mental health field a long time ago?

I just read with great interest the information on recommendations going to the Governor regarding credentialing, and I see nothing that would pertain to people like myself who are certified , credentialed,graduate trained social workers with all the credentials who are in the group of Registered Counselors.

I perused the proposal regarding the changes in the "Registered Counselor" certification, and was unclear on one particular area. (I do believe that people should not be allowed to "counsel" after merely sending a minimal amount of money into the state. changes clearly needed to occur.)

I am a registered counselor, who has been in private practice over the past year. I received a degree in counseling psychology, and completed a 250 hour internship at the Skagit Valley Hospital psychiatric unit. In addition, I have accumulated over 100 hours at the Play Therapy Training Institute in Hackensack, New Jersey over the past two summers.

During the past year, I have hired a child specialist who is a qualified supervisor. My practice is in the early stages, so I'm still a long way from licensure. I would fall in the cateogory of "master's level counselors working towards licensure."

In the proposal, it stated something to the effect that "those master-level counselors who have been practicing for over five years, might be able to continue practicing as long as they acquired supervision."

For those of us without that much experience, it sounded like we "wouldn't be able to practice independently." How is "independently" defined?

If we form an association with some other therapists, might that be an allowable format?

I'm still working as an elementary teacher in a local school district, but am eventually anticipating a job transition. Leaving my teaching job to work in a mental health agency would not be a vialble option for me since I have invested thousands of dollars and energy into my counseling education and for the intial expenses for my practice.

Hopefully, this part of the change can be adjusted to accomodate those of us who are seriously developing an effective practice.

First of all, I read the last email documents from Pamela Lovinger sent Aug. 11, 2006. As I understand the intent and purpose for the proposed changes is to protect the clients welfare, I'm still pondering what all these recommendations for licensure will do for my practice. Since I do not provide mental health counseling nor diagnose clients I questioned even further why I have the Registered Counselor license. It seems the task force is focused on counseling and the qualifications for doing such. Since I refer out such patients to licensed mental health professionals needing therapy I again question why I have this license(Registered Counselor). Thus, where do I go from here is my question to you?

If I'm practicing as a Life Coach exclusively in the State of WA what licenses do I need other than a business license through the City of Vancouver? If you can help clarify what I do need in order to keep my business operating I would be most appreciative. This after all is my livelyhood and I would be most appreciative for your views and recommendations.

My final question or comment is since I have a Masters in Vocational Rehabilitation Counseling and a Ed.S. in Marriage/Family Counseling and have over l5 yrs. of experience will folks like me be grandfathered into continuing licensure under the proposed changes?

The report was incredibly insightful and thorough. The questions/comments at the end were compelling and could no doubt expand the discussion on this important topic. As one of 3 citizen members on the Counselors Advisory Committee, and as the chairman of that committee, I rely upon our committee's representatives to address the technical aspects of the charge before the task force and am satisfied they have represented our committee well.

I note the draft report mentions public outreach. I strongly endorse that notion. It is important that guidelines, definitions, categories and designations pertaining to providers be as clear as possible - and the task force has done an excellent job of identifying many of those elements. I want to be sure though, that ordinary citizens who do not understand these elements of their mental health care are protected. In my mind, the surest way to accomplish this is through an extensive public awareness program. Unless the public is educated about what is to be expected from mental health care providers, they will continue to be targets for abusers.

Thank you for the opportunity to comment on this very important draft report.

I received a Diploma Degree in Psychoanalysis from the C. G. Jung Institute in Zurich, Switzerland. I have practiced Jungian Analysis in Washington State since 1998 as a registered counselor. I am a Training Analyst on the faculty of the North Pacific Institute for Analytic Psychology (NPIAP) in Seattle. Jungian Analysis is one of approximately 14 schools of Psychoanalysis. Unfortunately, Psychoanalysis is not recognized as a mental health discipline by the State of Washington. The present deliberations upon the category of Registered Counselors would seem to be a good time to reconsider this discipline.

NPIAP, where I teach and supervise candidates, is a 5 year program. We require candidates to have a Master's degree in a mental health field as a prerequisite to beginning the program. Ironically, I cannot accept insurance in Washington State while the individuals I supervise can. There are two reasons for this. First, while the requirements for a Diploma in Psychoanalysis are rigorous and uniform across the various schools, these are private institutions (several universities have granted Doctoral equivalency degrees to individuals based upon the completion of Psychoanalytic diplomas). The second reason dates back to the era of Freud and Jung and the debate over whether psychoanalytic training should be reserved only for those within the medical field. Both Freud and Jung concurred that psychoanalysis should not be confined solely to medicine. Later however, the well-funded AMA went to Congress and was able to reserve the term psychoanalysis for the domain of psychiatry. At the NPIAP we have 3 psychiatrists on our faculty who have gone through a Jungian psychoanalytic training and 1 psychiatrist currently in training to become a Jungian Analyst. However, only a tiny fraction of the psychiatrists who by law can call them psychoanalysts have actually completed a psychoanalytic training.

While perhaps confusing, New Jersey and Vermont, have redressed this situation by licensing psychoanalysts.

Should you wish to take on this noble task for the State of Washington, the National Association for the Advancement of Psychoanalysis in New York City can provide all needed information.

Psychoanalytic training is the only mental health discipline that requires the analyst to undergo his or her own analysis (a minimum of 300 hours). This, along with rigorous ethical training, is the best prophylactic against the types of transgressions that have lead to the formation of your group to reconsider the status of Registered Counselors.

First of all, I read the last email documents from Pamela Lovinger sent Aug. 11, 2006. As I understand the intent and purpose for the proposed changes is to protect the clients welfare, I'm still pondering what all these recommendations for licensure will do for my practice. Since I do not provide mental health counseling nor diagnose clients I questioned even further why I have the Registered Counselor license. It seems the task force is focused on counseling and the qualifications for doing such. Since I refer out such patients to licensed mental health professionals needing therapy I again question why I have this license(Registered Counselor). Thus, where do I go from here is my question to you?

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My final question or comment is since I have a Masters in Vocational Rehabilitation Counseling and a Ed.S. in Marriage/Family Counseling and have over l5 yrs. of experience will folks like me be grandfathered into continuing licensure under the proposed changes?

Thank you for getting out the Registered Counselor Recommencations.
I know it was a tremendous amount of work with a very tight time-line.

Though I would like to send in thoughtful comments and indeed like to spend time reading the recommendations before I do so, today's deadline makes that impossible. Your work deserves more consideration than I could give it by then.

Upon first reading, I think there are improvements in the disclosure requirement. I remain unsure that many of the other requirements will actually help with the problems that motivated the forming of the Task Force. Rather, it seems like they are simply likely to make being a counselor more difficult, which is unfortunate in a time when there is large and growing demand for assistance from a wide spectrum of our population.

We will plan on working with the Legislative staff next spring on these issues.

Thank you again for your work.

I am writing as a life-long Washingtonian who has practiced as a registered mental health counselor for nearly 33 years in my home town, Seattle.[1] I am a case in point of someone whose life and life long livelihood will be impacted drastically by the changes to public policy being proposed. While I have many concerns about due process issues in the conduct of this Task Force and the ways in which input from members of the affected class were systematically limited, given the late hour, I will limit myself to addressing some of the public policy issues of the anticipated legislation.

The draft recommendations make no provision for counselors to obtain State credentialing through the principle of equivalency of training and experience.

To discuss this concern, with your kindly indulgence, let me use myself as a case example. From my reading of the Draft Recommendations, all presently registered counselors, regardless of years of practice, equivalency of training or experience, record, or distinction, still would be required to obtain many quarters of expensive, time-consuming introductory college credit in ethics, counseling theory; human growth and development; and abnormal psychology. The education must specifically include assessing risk for suicide and homicide; the duty to warn; and duty to report abuse.

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[1] I was grandfathered as a Registered Mental Health Counselor under the 1987 Act.

Ironically, I am considered an international expert on the subject of suicide and self-injury. My courses on the subject are regularly accredited by the Washington State Social Work and Psychological Association, [2] and by similar organizations in many other states and countries. [3]

I have lectured and clinically consulted, by invitation, on the subject of suicide and self-harm, and my broader specialty area of treating post-abuse syndromes including dissociative disorders, to educational institutions, professional associations (psychiatric, psychological, social work, marriage and family), hospitals, mental health centers, and social service agencies across the United States, and in Canada, England, France, Germany, Australia, and Japan. My talks regularly address suicide assessment, risk management, and duties to warn and report.

For years, several of my published articles on these subjects have been part of the standard graduate curricula for social workers at Smith College and many others.

For 12 years, I was the lead consultant to the outpatient/adult services division of Seattle Mental Health Institute, the State's second largest mental health center.

I am a Fellow and founding member of the International Society for the Study of Dissociation. I also served, at the recommendation of Governor Locke and by Appointment of the Secretary of Health, on the Working Group on Dissociative Disorders and Dependency 1/97 - 4/98. Our task was to establish treatment standards for the dissociative disorders.

I also hold other professional certifications including Certified Diplomate of the American Psychotherapy Association {D.A.P.A.], and Certified Diplomate and Fellow in Clinical Hypnotherapy of the National Board for Certified Clinical Hypnotherapists.

A student of the late legendary hypnotherapist psychiatrist, Milton Erickson, M.D., I was one of 50 invited faculty at both the *1st and 2nd International Congresses on Ericksonian Approaches to Hypnosis and Psychotherapy* (Phoenix, 1980, 1983).[4] In 1993, *Self* magazine named me one of the top 10 hypnotherapists in America.

I have authored two books in my field and over 50 professional publications on hypnotherapy, marriage and family therapy, and the treatment of psychological trauma and child abuse. My last book, *The Couple Who Became Each Other and Other Tales of Healing From a Leading Hypnotherapist* (a featured alternate selection for the Behavioral Science Book Service), has appeared in North American, United Kingdom, French, German, and Israeli editions and garnered highly favorable reviews internationally. I founded and for seven years edited a professional journal for clinicians working with issues of trauma and abuse, with subscribers in all fifty states and in 21 foreign countries.

I am listed in *International Scientist of the Year* (2004), *Strathmore's Who's Who* (2003), *Who's Who in Science and Engineering* (2003), *Who's Who in Medicine and Healthcare* (2002), *Who's Who in Executives and Businesses* (2000), *Who's Who in America* (2000), *International Man of the Year* (1997), *International Who's Who of Intellectuals* (1997), *Who's Who in Executives and Professionals* (1994), *Outstanding People of the 20th Century* (1998), *Who's Who in Business Leader's* (1992), *Who's Who in the World* (1990), *Who's Who Among Human Services Professionals* (1988), *Who's Who Among Young American*

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[2] This year alone, the Washington State Psychological Association has accredited four of my programs for Psychological Continuing Education Credit. These programs included 1. Clinical Approaches to Self-Injury, Self-Mutilation, and Self Harm Syndromes (12 CEU), 2. Working with the Shattered Self: Treating the Spectrum of Dissociative Disorders and Dissociative Symptomology (24 CEU).

[3] Though I have let it lapse recently, I was granted status as an Approved Provider of the National Board for Certified Counselors (NBCC), authorized to grant continuing education credit hours for NBCC certified counselors. You will recognize this as the organization that conducts testing of licensed counselor applicants in Washington State.

[4] The 1980 meeting, drawing attendees from six continents, was the largest independent meeting of psychotherapists in history.

Professionals (1988), *Who's Who in Emerging Leaders of America* (1987), *And Who's Who in the West* (1984).

I am trained as a mediator and have worked with individuals, families, and organizations seeking alternative dispute resolution approaches.

Over 80% of my clients are referred to me by psychologists, psychiatrists, physicians, social workers and other mental health professionals.

I apologize for belaboring my credentials and accomplishments, but I feel it is necessary to make a point: **While I have gained having gained the respect and confidence of my peers and the clinical community locally and internationally and demonstrated high proficiency and competency, I have only a high school diploma**.

I took a non-traditional, autodidactic route to my professional education. Since 1976, I have taken well over three thousand hours of accredited, post-graduate level training on a variety of mental health topics including *inter alia*: biofeedback; communication theory; conference leadership; counseling methods; depression; dissociative disorders; mediation and family mediation, forensic interviewing techniques; psychoanalytic psychotherapy; Gestalt therapy; group facilitation; large and small group relations; habit control; hypnotherapy; child abuse; legal aspects of counseling; marriage and family therapy; memory; pain control; brief, solution-oriented therapy; stress management; post-traumatic stress disorder (PTSD); vicarious and secondary traumatization; and transference and countertransference; organizational psychology; parenting plans, and so on. Much of this training was with world leaders in the field of mental health.

The proposed changes to the law, as regards the educational requirement for presently registered counselors, make no distinction between me--a highly trained, principled and effective practitioner with internationally recognized expertise--and a registered mental health counselor with little or no experience or training. Regardless of these important distinctions, I would be mandated to take many hours of introductory counseling classes similar to classes I have taught myself at the graduate level. There are no provisions in the draft recommendations that would allow someone such as me to challenge the educational requirement with an equivalency of training and experience. The net effect of the proposed recommendations is that at the age of 57, when my family's need for income is as great as ever, I actually would have to cut back my practice [5] and accrue significant expense in order to take college classes in areas for which I have amply demonstrated competence, many of which I am certified to teach for continuing education credits to licensed practitioners in this State.

Beyond issues of fairness, equity, and effectiveness of an approach that singles out only one class of regulated profession, this one-size-fits-all approach to educational requirements will serve to stifle diversity. The 1987 Legislature's clear intent was not to inhibit the free and diverse practice of counseling or the public's right to choose. The legislative findings state in part:

> The Legislature recognizes the right of all counselors to practice their skills freely, consistent with the requirements of the public health and safety, as well as the right of individuals to choose which counselors best suit their needs and purposes.

The 1987 legislature specifically intended to include the RMHC designation. They recognized that there are thousands of ethical, competent, conscientious, and well trained counselors with valuable depths of experience and knowledge, who took alternative, autodidactic tracks to their professional education and competency. Now as then, but for lack of a formal educational credential, they could be certified. In view of this, the enabling act authorized an *equivalency of education and experience* track on which registrants could challenge for certification without an educational credential.[6] The clear intent of the legislature was

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[5] I work 10 – 11, back-to-back clinical hours each day. To go back to school to satisfy the proposed educational requirement, I surely would have to cut back my practice and thus my income.

[6] Regrettably, this aspect of the legislative intent was lost when the new law was written into administrative code by DOH. These first drafters added an *educational credential requirement* for all

not only to allow RMHCs to practice, but also to require, for the first time, that they register and practice under the regulatory authority of the State. In this way, they increased consumer protections while preserving consumer choice.

The thousands of RMHCs in Washington provide a valuable, often lower cost and more flexible alternative for the consumer. Often free from stricture by third party payers, RMHCs often can be more flexible in adjusting their services and fees to suit the resources of their clients. By comparison, for example, of the more advanced credentialed professions who accept insurance patients, many are prohibited by contract from offering a reduced fee to low-income, out-of-pocket clients.

What public health problem(s) do proponents of increasing regulatory purview over registered mental health counselors purport to solve?

I propose that the only proper test for determining whether changing the law for one class of regulated profession serves the public's best interests is 1) whether there is an accurately defined problem, supported by data, that demands legislative or administrative action, 2) whether the intended actions will specifically solve the defined problem(s), and 3) whether this attempted solution will create wicked new problems or unwitting adverse consequences that offset any potential good for the public or the mental health professions.

Presently, RMHCs comprise the majority of non-medical mental health service providers in the State of Washington. Those who suggest we single out RHMCs for increased regulatory purview sometimes justify their proposals with a dubious claim that RMHCs have a significantly higher rate of complaints than other regulated mental health professions. This, however, does not appear to be supported by the data that policy makers readily have before them.[7] Laura Groshong, a well known mental health lobbyist who has personally promoted the increased regulatory purview over RMHCs for years has circulated her own data.[8] These data indicate the complaint rate for RMHCs (**2.6%**)[9] is actually *less than* that for Licensed Mental Health Counselors (LMHC) (**2.8%**) and Licensed Marriage and Family Therapists (LMFT) (**3%**). Licensed Independent Social Workers (LiCSW) had the lowest rate (**1.9%**) of the four groups listed. Ms. Groshong's summary did not include complaint rate data for Licensed Clinical Psychologists, slightly over **4%** in 2003, [10] hence topping the list.

Thus, contrary to the stereotypic claim that RMHCs have relatively high rates of complaint, the data strongly suggest RMHCs receive complaints at rates comparable to the other regulated groups. Nor do the data suggest that RMHCs have significantly higher rates of disciplinary actions taken.[11] Moreover, given

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certified positions, not intended by the enabling act. Shortly after these administrative rules were announced, I hired an attorney to help me challenge the educational credential requirement on the basis it did not reflect legislative intent. Because such an action would require costly depositions of many people, however, I was not able to proceed.

[7] The Department of Health (DOH) has consistently reported rates of complaints against registered counselors consistent with the other regulated groups.

[8] *Complaint Data on Registered Counselors, LiCSW,* [sic] *LMFTs, and LMHCs for the 2001-2003 Biennium*, April 24, 2004.

[9] The complaint rate percentages listed in Ms. Groshong's document are *all* inflated by a factor of 10, an apparent computational error. The percentages I cite from her document are *corrected* figures. However, the data is also confusing in another way. It is unclear whether the total numbers of complaints listed are for one or two years. If they represent figures for the entire 2001-2003 biennium, then the annual rates may actually be half of those given.

[10] Source: Craig Anderson, Public Disclosure Coordinator, Department of Health.

[11] Ms. Groshong gave 129 as the number of disciplinary actions taken against RMHCs in the 2001-2003 biennium. This is variance with the data I obtained from DOH that shows that of the 418 complaints received: 242 were investigated, 62 had no investigation, 79 had no action taken, 26 were closed prior to investigation, 13 closed after investigation, 11 notices of correction given, 25 went into default, 52 informal orders, and 5 hearings. It is unclear whether the hearings all led to disciplinary action, but even assuming for the moment that they all did, the total number of disciplinary actions taken against

these arguably low complaint rates overall,[12] the differences among groups (range 1.9 % – 4 %) may not be highly significant. Such differences may be due to other factors, such as differing levels of vulnerability to complaint among the groups (including factors such as involvements with the school system, the legal and criminal justice system, insurance carriers, hospitals, and other institutions, as well as variables such as the level of fee charged, perceived status, mandated standards [e.g., HIPA, Medicaid, Social Security, DVR, crime victims' compensation] and so on).

Ms. Groshong's complaint data summary also includes data about criminal convictions and disciplinary action taken for the four practitioner groups she lists. As I believe there are some serious problems with this data that could well lead to false conclusions, I will discuss them. For the RMHC group, Ms. Groshong indicates that the number of applicants with criminal convictions is 324, [13] [14] which she indicates represents a rate of 6%. I cannot see how she arrived at this figure. 324 is actually only 2% of total registrants (15, 820),[15] which compares much more favorably to rates given for the other groups.

More importantly, though, DOH claims the elevated criminal conviction rate for RMHCs is skewed for the following reason. A large number of RMHCs are Chemical Dependency Professionals (CDP) who come from the ranks of recovered users and thus many bring with them criminal convictions. In these cases, DOH makes a referral for mandatory investigation. Given this clarifying variable, it is probably inaccurate to conclude that the data suggest that RMHCs have significantly higher rates of criminal activity than the other groups.

A false and misleading impression?

With little hard data suggesting RMHCs as a group pose a greater hazard to the public than the other regulated professions, proponents of tougher strictures instead rely on sensible sounding authoritative assertions and hypothetical scenarios. They argue, for instance (without survey or other data), that the

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RMHCs for the period is 93, not 129, or an annualized rate of about 0.5%, very favorably comparable to the other groups.

[12] These complaint rates seem to compare favorably with various other professional services:.

- Studies of medical malpractice show that approximately <u>1-6</u>% of hospitalized patients experience unexpected adverse outcomes and that approximately one third of these are associated with medical negligence (California Medical Association and California Hospital Association. Report of the Medical Insurance Feasibility Study. San Francisco, CA: Sutter Publications, 1977; Brennan TA, Leape LL, Laird N, et al. Incidence of adverse events and negligence in hospitalized patients: Results of the Harvard Medical Practice Study. *NEJM* 1991;324:370-376).

- The US Department of Health and Human Services studied complaint data from 10 States with the largest nursing home populations and found complaints of abuse and negligence of <u>6.5</u>% (per bed) in 1996 and <u>6.9</u>% in 1997 (U.S. Department of Health and Human Services, Office of Inspector General. Long Term Care Ombudsman Program: *Complaint Trends*, March 1999).

- The combined average annual rate of consumer complaint for the 19 largest New York State Utilities (water, gas, electric, cable, telephone) in November 2002 was <u>2.26</u>% (New York State Public Service Commission, Office of Consumer Services, *Monthly Report on Consumer Complaint Rates*, November 22, 2002).

[13] There are no source citations given in Ms. Groshong's summary for reported numbers of criminal convictions.

[14] This data is confusing. It is unclear whether the quantity, "number of applicants with criminal records," represents a sub-set of all registered counselors or a sub-set of the total group of applicants who applied for registration, including any that were denied. Since no figures are given for total number of applicants, I will assume that Ms. Groshong is comparing the number of convictions to the total number of registrants.

[15] I was given a different total for registrants by Tammi Benson, DOH Program Manager for registered counselors, who told my office (July 1, 2004) the total number of RMHCs is *16,689*. If we use this total figure, the percentage of registrants with criminal convictions is 1.94%.

RMHC designation *cultivates (mass) confusion* in consumer's minds between licensed and merely registered counselors. Thus, as the scenario goes, registration promulgates a false and misleading public impression that RMHCs are "recognized statutorily by the State." Removing the RMHC category, they envision, would indicate to consumers that all (remaining) mental heath clinicians are recognized statutorily by the State which, they say, will "professionalize" the mental health field and thus, they argue, raise standards of practice.

This argument proceeds *a priori* from the assumption that the State's imprimatur somehow certifies quality of care for the public. Yet statutory recognition of licensed *and* registered mental health practitioners is *unrelated to clinical competency, safety, or effectiveness.* Statutory designations attest only to the practitioner's levels of prior training (or lack thereof) and specialized knowledge. Unless conducting an investigation, the State is formally blind to the typical clinician's competency, safety, and effectiveness. Whatever changes to the RMHC designation the legislature may enact, statutory recognition of providers (of any level) neither warrantees the public against incompetent or unethical practice nor guarantees a higher standard of care. Witness the significant numbers of complaints brought against supposedly highly trained and credentialed licensed psychologists and psychiatrists for practice beneath standard of care or for patient impropriety. **The data indicates that advanced certification or licensure, though arguably desirable, does not result in lower complaint rates.**

Will the proposed changes to the law raise standards of care?

Proponents of deregulation argue that eliminating the RMHC designation will lead to higher standards of practice for the field.[16] Proponents rest their arguments to single out RMHC's for special attention on the unproven assumptions that generally less trained and credentialed RMHCs degrade the standard of care and that licensing agencies measure professional competence, a scientifically debatable proposition. Over the last 25 years, reputable investigators have increasingly challenged whether licensing agencies actually measure professional competence, or simply what knowledge can be measured easily. They claim little evidence exists that depth of knowledge content alone relates to performance superiority. The psychologist, Pottinger, for example, found to the contrary: that sheer amount of knowledge of a content area "is generally unrelated to superior performance in an occupation . . . [or] even to minimally acceptable performance." [17] Yet knowledge of content is predominantly what is measured in the multiple-choice format of most written licensing exams. Psychologist-lawyer, Hogan, argued that "standardized national examinations have not been shown to have anything more than face validity." [18]

Similarly, although *academic credentials* are universally required by regulatory authorities, training does not identify the competent psychotherapist,[19] nor are grades or degrees found to be related to professional

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[16] This argument mistakenly assumes there is (or ought to be) *one* standard of care for the mental health field. Yet each regulated group has *its own* ethics codes and standards of care that are constantly refined through collective, peer-leveled clinical experience, and shaped by professional, legal, administrative and other precedents. Distinct standards already exist for RMHCs, for example, for informed consent and disclosure, note taking, confidentiality, professional misconduct, and so on. RMHCs also join a great variety of professional societies in which they agree to be bound by various professional codes of ethics.

[17] Paul S. Pottinger, "Competence Testing as a Basis for Licensing: Problems and Prospects," paper presented at the Conference on Credentialism, University of California Law School, Berkeley, Calif., 1979, p. 8.

[18] Dan B. Hogan, "The Effectiveness of Licensing: History, Evidence, and Recommendations," Law and Human Behavior 7 (1983): 123.

[19] Dan B. Hogan, *The Regulation of Psychotherapists*, vol. I; Parloff, "Can Psychotherapy Research Guide the Policymaker?"

accomplishment generally.[20] Hogan wrote, "A wide range of research indicates that academic grades predict nothing but future grades or results on tests similar to those used in establishing grades." [21]

Hogan instead found *work experience* an excellent predictor of competence. [22] He cited, for example, the comparable psychotherapeutic effectiveness often reported for paraprofessionals and for lay persons trained on the job. He and others say this data should raise doubt about the importance of theoretical and technical knowledge for minimal level competency. [23] They suggest that academic training is compromised as a basis for restricting entry to the field since outcome measures, such as psychotherapeutic effectiveness and diagnostic accuracy, indicate such training makes little observable difference. They suggest that non-academic (autodidactic) routes to competence be recognized by licensing authorities and that the assessment of competence should relate directly to performance and practice, rather than background.

In his four volume treatise, *The Regulation of Psychotherapists: A Study in the Philosophy and Practice of Professional Regulation*, [24] Hogan concluded that regulation had protected the professions more than the public. Legal, administrative, and professional forces had colluded to create a kind of guild system that protects the professions' interests over the public's. On the basis of this seminal work, some states deliberated sunsetting their licensing laws.

Since the relationship between licensing and quality is still being debated in the scientific community, we cannot conclude categorically that eliminating or more highly regulating non-licensed categories would raise standards of practice.

Would the proposed changes to law result in unintended negative consequences?

The proponents argue that deregulation is a much needed reform that will only benefit the public. They seem not to have considered the potentially adverse consequences of such a bold change in public policy. Certainly, the concerns discussed above (though not intended to be an exhaustive list of potential pitfalls) merit serious consideration.

Would the proposed changes raise serious restraint of trade issues?

Throughout this discussion, I have assumed proponents of changes in the regulation of RMHCs simply want to increase the State's regulatory purview over RMHCs. Now, let me consider the other scenario: that the ultimate intent of this bid is to drive some proportion of the 18,000 registrants from practice.

Due to economic and other considerations, such proposed actions could well eliminate from the profession many conscientious and well trained practitioners whose services have contributed to the public welfare and who typically offer more affordable and flexible alternatives to licensed practitioners. With no grandfather provision and no equivalency of training, education and experience track for certification anticipated in the draft recommendations, they might effectively preclude from practice or limit the practice of persons such as me who have demonstrated competency and who have contributed to the public weal.

Moreover, such action would have an adverse economic impact on ethical and competent registered counselors (and their families) who were promised by the Legislature that their right to practice would not

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[20] Randall Collins, The credential society: An historical sociology of education and stratification, New York: Academic Press, 1979.

[21] Dan B. Hogan, "The Effectiveness of licensing: History, evidence, and recommendations," *Law and Human Behavior*, 7(1983) p. 122.

[22] Dan B. Hogan, *The Regulation of Psychotherapists, vol. I: A Study in the Philosophy and Practice of Professional Regulation,* Cambridge, Mass.: Ballinger Publishing, 1979.

[23] Dan. B. Hogan, *The Regulation of Psychotherapists, vol. I; Parloff*, "Can Psychotherapy Research Guide the Policymaker?"

[24] Dan B. Hogan, *The Regulation of Psychotherapists, vol. I: A Study in the Philosophy and Practice of Professional Regulation,* Cambridge, Mass.: Ballinger Publishing, 1979.

be impeded. Such an action might create a whole new class of jobless, most of whom would not be eligible for unemployment compensation.

The present effort to increase DOH purview over a single class of practitioner, promulgated by representatives of other regulated groups (without much data to support the hypothesis that the targeted group poses an elevated risk to the public), raises serious restraint of trade issues. RCW 19.86.040 states in part**, "**It shall be unlawful for any person to monopolize, or attempt to monopolize or combine or conspire with any other person or persons to monopolize any part of trade or commerce."

I am aware that when several other states attempted to drive hypnotherapists as a class from practice, each of these efforts was defeated on the basis of restraint of trade arguments. This included a successful effort in California, arguably the strictest of all state licensing authorities.

I am in touch with two national organizations that primarily represent RMHCs. Both have expressed a strong interest in joining a class action restraint of trade suit, should it become necessary, against the State and any NGO that actively tries to drive an entire class of practitioner from business or subject it to inequitable, selectively applied rules. Certainly, none of us hopes for this outcome, but it would incautious for any party to this debate not to recognize the real possibility of such a legal action if this proposal proceeds to law. I doubt that 18,000 potential litigants would all simply walk away from their livelihood without a fight.

Summary and conclusion

I proposed a three-fold test for determining whether the draft recommendations serve the public's best interests: 1) whether there is an accurately defined problem, supported by data, that demands legislative or administrative action, 2) whether deregulation will specifically solve the defined problem(s), and 3) whether this attempted solution will create wicked new problems or unwitting adverse consequences that might offset any potential public good. As I have shown, the proposal fails all parts of this test. Based on the proponents' arguments, as well as my own research and analysis, I cannot see how the draft recommendations address *any* identifiable compelling State or public interest. Worse, the proponents seem to lack an in-depth understanding of the potentially deleterious impacts of their plan on the consumer public.

These draft recommendations, applied selectively to a class of practitioner that does not even have the highest rate of consumer complaints, holds out the prospect of harm to the public and damage to thousands of responsible registered practitioners. It is a solution in search of a problem. As such, some proponents give the unfortunate impression of being more involved in an internecine or political struggle than a thoughtful consideration of the public interest.

If I can further the discussion of this issue in any way, please let me know. Thank you for your consideration and for your efforts on behalf of the State's citizens.

Thank you for the opportunity to review the draft report. The report is well written and accurately describes the process and the product of the study that was conducted. It does not, however, provide adequate analysis and justification for the substantial policy change that is being recommended.

Before fixing a problem, good public policy analysis requires that the problem be clearly defined and documented. I hate to say it but at this point the recommendations appear to be more a response to sensational journalism and protectionism by mental health professionals, a triumph of form over substance, than solid policy development.

What are the problems?

1. People don't know what registered counselors are and what they do.

Though it was not demonstrated in the study the conventional wisdom that most people don't know the difference between registered counselors and what they do and licensed mental health professionals and what they do or the differences in the types of preparation each has for the services they provide can be accepted. What this indicates is the need for improved pubic education and information and the need for adequate disclosure by practitioners of counseling services to their clients and potential clients. The recommendations do address this.

Protecting the public should not mean denying them access to services they want. This is what the recommendations accomplish. Barring hard evidence to the contrary, public policy must respect the ability of people to make decisions for themselves in their own best interest.

2. People are providing types of therapeutic mental health services for which they have not received adequate preparation – education, supervised experience and ongoing supervision and continuing education.

It is legitimate for licensed mental health counselors to want people who are doing the things that they do that required LMH counselors to meet specific requirements before doing so to expect that other people who are doing the same things that they do, i.e., using specific therapeutic procedures, to have equivalent training or work in supervised settings. But this is very different than saying that anyone who works with another person to assist them with issues of self-understanding and life adjustment, whatever methods they utilize, must meet mental health counseling standards. Mental health counseling is one form, one discipline of counseling practice and services. It is not the only one. DOH public policy recommendations should not give exclusive privilege to one type of counselor when the data don't substantiate the necessity of such action.

No evidence was provided in the course of the study that demonstrated that significant numbers of clients of registered counselors have failed to receive self-knowledge and life adjustment benefits or have been excessively harmed by the services they have received from registered counselors who are not licensed mental health practitioners or working in professional mental health counseling settings under the supervision of licensed mental health counselors.

3. The lack of formal education and experience requirements leads to client mistreatment. (Comparable data for all counseling professions was not provided.)

The only evidence provided that might possibly support this was presented to the task force but has been left out of the report. This is a significant omission. It could call into question the objectivity of the study, compromise its legitimacy as a policy study and raise serious questions about the reason for the policy changes put forward as recommendations.

The data on disciplinary actions do show a 30% increase in actions against registered counselors between 2001-03 and 2003-05. In that same period mental health counselors had a 300% increase and chemical dependency counselors an 88% increase. Other mental health counselor professions showed a decrease or remained constant. These data do not substantiate that education; supervised experience and ongoing supervision necessarily protect clients from inappropriate activities by their counselors. It is a much more complex problem that will not be resolved by the proposed recommendations.

Clearly action needs to be taken to reduce the incidence of actionable activities by registered counselors but the solution presented in the recommendations does not receive anything like clear substantiation from the data.

Much attention has been directed to the problem of sexual abuse by registered counselors. The data presented to the task force are limited but reviewing the data on current cases reveals that of current cases in the Office of the Attorney General, sexual misconduct cases constitute:

44% of cases for registered counselors
40% of cases for chemical dependency counselors

50% of cases for .licensed mental health counselors
50% of cases for licensed marriage and family therapists
33% for social worker counselors
100% for multiple credentialed
(No data were provided for psychologists)

All numbers on which these percentages were calculated were small and subject to the error of small numbers so this evidence should not be overstated. Nonetheless, the risk to clients for sexual misconduct by registered counselors does not appear to be different that that from mental health professionals. This does not support the idea contained in the recommendations that supervision by a licensed mental health professional somehow assures that registered counselors won't engage in sexual misconduct. This seems to be a case of the soot stained pot not only calling the kettle black but contending that it is the one best able to keep the kettle clean.

The change in public policy and requirements imposed on persons wanting to continue to be registered counselors by the recommendations in the report are not substantiated by the factual evidence.

It is also useful to look at the proportion of disciplinary actions relative the number of individuals holding credentials in the counseling professions. The data that were presented only permit comparison for the 2003-05 biennium. During this time the proportion of actions to credentialed persons was:

Registered counselors	.96%
Chemical dependency counselors	1.80%
Licensed mental health counselors	.49%
Licensed marriage and family therapists	.44%
Social worker counselors	.14%
Psychologists	.37%

(These are treated as though each action was against a different person. There is no way to tell from the data if the same person may have had more than one action taken against them.)

Actions against registered counselors were greater than all but chemical dependency counselors. The number of actions taken is very small for all counseling professions. The incidence of disciplinary actions must not be overlooked but the complete rewriting of state policy in the hope of eliminating the problem is not supported by the evidence. Mush more research into the disciplinary experience is required to better understand what is actually happening, who is involved in disciplinary procedures, what their qualifications are so the real problem can be addressed by meaningful remedial actions including policy changes if ultimately that is determined to be required.

In 1985 people who counsel others for a fee were required to register and were placed under the UDA to provide public protection. The evidence shows that this was good public policy that is working.

If one compares the per-capita disciplinary actions in 2003-05 for registered counselors, .96%, to that for all credentialed mental health professionals, .67% one must ask if this difference has sufficient statistically significance to warrant the proposed change in policy. One must further question the extent to which the changes will actually be better able to achieve the increased public protection that is desired than will better public information and education and enhanced, more standardized disclosure by registered counselors. Until the latter have been implemented under existing policy, are tried and are demonstrated to be inadequate there is no real basis other than politics and protectionism to proceed to recommend the proposed policy changes.

WHAT SHOULD THE DEPARTMENT RECOMMEND BASED ON THE DATA AND TASK FORCE DELIBERATIONS?

It would be far better for the department to bite the bullet and, despite sensational journalism, unapologetically tell the governor that DOH is doing a good job regulating registered counselors and show her the data that back that up.

DOH should the recommend and model improved disclosure.

The department should develop and make available on-line training for registered counselors on the nature of power in counseling relationships and the responsibilities of counselors.

The department should also develop and make available on-line information that will help registered counselors recognize abnormal psychological conditions and make appropriate referrals.

If these training programs are made readily available at minimal to no cost they should be credentialing requirements like HIV/AIDS training currently.

Finally, respecting the desire of the mental health counseling professional community, at least as it was represented on the task force, to tighten up their levels of professional practice those specific recommendations should go forward.

Registering counselors who are not mental health practitioners should be continued so that these individuals remain under the successful application of uniform disciplinary procedures.